TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, March 28, 1900.

The President, B. FARQUHAR CURTIS, M.D., in the Chair.

LONG IMMUNITY FROM RECURRENCE AFTER RESECTION OF A SARCOMA OF THE LOWER JAW.

DR. A. B. JOHNSON presented a girl, who first came under his care when four years of age. About the beginning of 1892, or eighteen months before she came under his care, her mother noticed an enlargement of the lower jaw upon the left side and a little removed from the median line. This enlargement continued to increase in size. It was painless, and caused discomfort chiefly on account of its size. An incision had been made into the growth some months before from within the mouth, but without benefit.

Upon examination the child was found to be fairly nourished; a marked deformity of the lower part of the face was noticeable. The mental, submental, left submaxillary, and a portion of the left parotid regions were occupied by a large rounded tumor about the size of a large mandarin orange, the skin overlying the tumor being healthy and not adherent. The mucous membrane of the mouth not ulcerated, the tongue displaced towards the right by the projection of the mass into the floor of the mouth.

The enlargement seemed to include the entire circumference of the body of the jaw. The tumor was smooth, rounded, and hard to the touch. In front a crackling sensation could be produced by pressure with the finger, as though the shell or bone surrounding the mass was very thin.

May 4, 1892, an incision was made from the middle of the chin outward and backward over the growth as far as the angle of the jaw. The tumor was found to extend to the right some

distance beyond the median line, and the jaw was sawn at a point opposite the second incisor tooth on the right side, and again at the junction of the body with the ascending ramus upon the left side. The periosteum appeared healthy, and was spared as far as possible. The patient made a good recovery. Upon inspection, the tumor was found to consist of a thin shell of bone surrounding a large cavity filled with a rather soft tissue of a uniform white-yellowish color. The development of the teeth appeared to be perfect. The soft tissue upon examination proved to be a sarcoma containing round cells and many giant cells.

The patient has been kept under observation since the operation was done; a slow regeneration of bone has taken place, and at present the continuity of the jaw appears to be complete, although the new bone does not at all approach a normal inferior maxilla. For several years the child has been wearing a plate containing some teeth. It seems to be fairly efficient. The deformity is only moderate, if one takes into account the extensive removal of the bone.

One of the chief factors of interest in the case was the regeneration of the bone, which had taken place with exceeding slowness. He had first noticed the new growth of bone about two years ago.

ACUTE INTESTINAL OBSTRUCTION FROM ADHESION BANDS FOLLOWING APPENDICECTOMY.

DR. ALEXANDER M. JOHNSON presented a man, aged thirty years, who entered the Roosevelt Hospital on January 8, 1900, with the following history: Fifteen years before he had a severe attack of illness, which seems to have been due to an inflammation of the vermiform appendix. He remained well after recovery from this attack until five months ago, when he had a typical attack of appendicitis, severe in character, confining him to his bed for many days and terminating in an imperfect recovery, the region of the appendix having remained tender upon pressure ever since. Three weeks ago he had another severe attack accompanied by the formation of a tumor in the right iliac fossa. Since then he has lost strength and flesh, and has constantly suffered from considerable discomfort, referred to the region of the appendix.

Upon admission to the hospital his evening temperature was

100° F.; pulse, 84. There was tenderness on pressure and a slight sense of resistance to be felt over the appendix. He remained under observation until January 20, during which time he had a slight evening rise of temperature. The local conditions remained about the same.

Upon January 20 the abdomen was opened by the intermuscular incision of McBurney. The cæcum was found to be firmly adherent upon its outer and posterior surfaces to the peritoneum covering the iliac fossa. After a rather tedious dissection, a small abscess was opened, which contained about one-half a drachm of pus. This abscess was found to communicate, on the one hand, with the open end of an appendix about an inch in length, a considerable part of the organ having apparently been destroyed, and on the other with a small opening in the wall of the cæcum at a point about an inch and a half distant from and below the base of the appendix. The cavity of the abscess was wiped out and the granulation tissue forming its walls was removed with a curette. The hole in the gut was closed with several mattress stitches, the appendix was amputated at its base, surrounded by a purse-string suture and inverted in the intestine.

The necessary manipulations of the cæcum were prolonged and severe. A small drainage wick was placed in contact with the sutured portion of the gut and the cavity of the abscess, and led out through the abdominal wound. The remainder of the wound was closed by sutures. The patient bore the operation well; his temperature rose after forty-eight hours to 101.8° F. He vomited several times on the day following the operation; and, although on the next day his temperature fell to 99°, and remained at that point for the following five days, his stomach continued irritable.

His bowels moved freely upon the third day; the vomiting was greatly diminished in frequency by washing the stomach. The wound remained entirely clean except for the discharge of a small amount of pus along the sinus created by the drainage wick. At the end of a week his condition was entirely satisfactory; but on the eighth day the vomiting recurred. He had had one or more movements daily from the bowels up to this time.

Although the wound remained clean, his temperature rose on the tenth day to 101.8° F. During the ninth and tenth days following the operation he began to vomit more often, and to

complain of pain in the stomach after taking food; his bowels became difficult to move, and upon the tenth day the vomited material changed in character, became of a dark brown color and had a disagreeable odor. He also suffered from severe abdominal pains, and his pulse showed signs of failing strength.

Upon the eleventh day he did not vomit; his bowels moved once; but upon the following day the vomiting and abdominal pains recurred. Upon the fourteenth day this condition was more serious, the vomiting and pain continued, and the vomited material was of a decided fæcal character. Numerous high enemata brought away only small amounts of fluid fæces mixed with mucus and blood. He began to grow very weak and to suffer from abdominal distention with severe abdominal pains. His pulse became very rapid and feeble in spite of powerful stimulations.

On the morning of the fifteenth day the signs of acute intestinal obstruction were unmistakable. His eyes were sunken, his extremities cold, his abdomen distended; he vomited frequently, and the vomited materials were distinctly stercoraceous. The bowels could not be made to move. Accordingly, upon the fifteenth day he was etherized, and a median abdominal incision was made with its centre opposite the umbilicus; the peritoneum was clean, but coils of distended and congested small intestine presented in the wound. These were pushed towards the left, when other coils of small intestine were seen in a collapsed state, which being followed led to the right side of the abdomen in the region of the ascending colon. The ascending colon and two coils of small intestine were found agglutinated into a solid mass. The coils above this mass were distended, those below were collapsed. Upon further examination, a broad fibrous band was seen passing from the ascending colon towards the left, behind it was the outermost coil of small intestine. Its calibre was completely shut off by the pressure of this band. The inner coil did not appear to be completely obstructed, and the band extended across its front to be attached upon the further side to its mesentery. The band was divided and, as far as possible, cut away with the scissors, when the collapsed coils immediately filled from above.

The two coils of small intestine, however, were found firmly adherent to one another over an area represented by nearly half their surfaces, for a distance of about three inches. They were

separated with difficulty. The bleeding during these manipulations was considerable, and the patient's condition indicating an alarming collapse, he received a hot saline intravenous infusion of 2000 cubic centimetres.

Temporary pressure was applied to these bleeding surfaces by means of gauze pads, and the pelvis was explored for other possible causes of obstruction. Numerous bands and broad adhesions were also found between the coils of small intestines situated in the pelvis; although not apparently causing trouble, the bands were cut away. The broad adhesions were let alone. The bleeding here was checked by temporary packing. The coils of small intestines which had been obstructed were moved as far as possible towards the left side of the abdomen. The site of the operation was thoroughly washed with hot salt solution and wiped dry.

The abdominal wound was closed with sutures except at its lower part, where an opening was left for two strands of gauze, leading from the bottom of the pelvis and from the inner side of the ascending colon, where it had been adherent to the small intestines. Although very weak, the patient responded to the most active stimulation, and upon the following day a small movement from the bowels occurred as the result of an enema. His temperature rose to 102.4° F. at the end of forty-eight hours. He was fed chiefly per rectum for two days, after which, the vomiting having subsided, he was given liquid nourishment by the mouth. At the end of forty-eight hours an abundant movement of the bowels occurred, after which movements occurred regularly without trouble. His abdominal wound healed for the most part per primam, and he has now almost a linear scar. The abdominal wound remained clean, and the packing was removed at the end of the fifth day and replaced by a much smaller quantity. His convalescence has been slow but uninterrupted.

DR. HOWARD LILIENTHAL asked why Dr. Johnson had waited until the fifteenth day before doing the second operation. Given a history of previous operation for an inflammatory abdominal disease, why should one wait for fæcal vomiting, or even vomiting approaching that in character, before operating?

Dr. Lilienthal said he had had three cases somewhat similar to the one reported by Dr. Johnson. In one of them the secondary obstruction came on a number of months after the primary opera-

tion, and in the other two a few weeks afterwards. In all three of them, the speaker said, he operated just as soon as the symptoms pointed to an abdominal obstruction, without waiting for fæcal vomiting. All three patients recovered.

DR. JOHNSON said that his patient gave a history of always having had a sensitive stomach, and the vomiting commenced immediately after the primary operation. Furthermore, the intestinal obstruction was not complete, the patient a number of times passing small quantities of gas and fæces. At times the vomiting ceased entirely. The primary operation, Dr. Johnson said, was done to relieve a chronic appendicitis; and, although a small abscess communicating with the appendix was found, there was no general invasion of the abdominal cavity, consequently, extensive peritoneal adhesions were not expected.

A FURTHER STUDY OF STARVING MALIGNANT GROWTHS BY EXCISION OF BOTH EXTERNAL CAROTIDS.

DR. ROBERT H. M. DAWBARN read a paper with this title.

In connection with this paper, Dr. Dawbarn presented four patients upon whom he had operated by this method.

DR. GEORGE E. BREWER asked Dr. Dawbarn whether he thought excision of the arteries was necessary in the case he had reported of giant-celled sarcoma of the jaw, which he was able completely to remove. It is quite unusual to observe recurrences after the complete removal of an epulis.

DR. WILLY MEYER said the same question had occurred to him. We know that if the so-called epulis or giant-celled sarcoma is freely excised, the result is usually good, and even after a single recurrence it is questionable whether such a radical operation as excision of both external carotids should be resorted to for this purpose. After a second recurrence, that procedure might be advisable.

Dr. Meyer said that in June, 1890, at the German Hospital, he tied both external carotids as a preliminary step to excision of the superior maxilla for sarcoma. This rendered the operation almost entirely bloodless. It was certainly advisable to do this in every instance where the patient cannot afford to lose much blood. In the case he referred to, the tumor had already invaded

the orbit and involved the temporal region. Recurrence set in, to which the patient succumbed ten months later. The speaker said he had never resorted to excision of both external carotids, as suggested by Dr. Dawbarn. The expedient appeared, however, very reasonable, and should be carried out in suitable cases.

DR. F. KAMMERER said he had operated on a number of cases of epulis, and to his knowledge there had never been a recurrence after a liberal removal of the growth, when the tumor was of the giant-cell variety.

DR. DAWBARN said he had employed general anæsthesia in all his cases. The speaker said that in his single case of giant-celled sarcoma, with epulis, he was partly influenced to resort to the radical procedure of excising both external carotids by the fact that the patient was a young woman, whose beauty—and, consequently, her future matrimonial chances—would have been greatly marred by a recurrence, which would have necessitated excision of the upper jaw. We know that even giant-celled sarcoma sometimes recurs, and that with other forms of sarcoma a recurrence is the rule. To this rule, the case shown by Dr. Johnson was apparently a remarkable exception, especially as the periosteum had not been removed.

CYSTIC DISTENTION OF THE INTERNAL SAPHENOUS VEIN SIMULATING A FEMORAL HERNIA.

DR. DAWBARN presented a specimen obtained from a woman, sixty years old, who was admitted to the Polyclinic Hospital on January 1, 1900, with the diagnosis of left femoral hernia of six weeks' standing. She had a swelling, about as large as a hen's egg, in the left femoral region, which she stated had come on after lifting a heavy washtub. Upon straining, the tumor would increase in size somewhat, and taxis would make it disappear, which it did without gurgling.

Dr. Dawbarn said that, after examining the patient, he suspected a strangulated femoral hernia. An incision, however, revealed that the swelling was nothing more than a sacculated dilatation of the internal saphenous vein at its upper end. The patient made an uneventful recovery, and returned to her home on the tenth day. She had no varicosities in other regions of the body.

DR. KAMMERER said that about a month ago he was asked to see a patient at St. Francis Hospital,—perhaps the same one upon

whom Dr. Dawbarn had operated. The patient was a woman who had been sent in with the diagnosis of a femoral hernia. There was slight impulse upon coughing. Dr. Kammerer said that after a careful examination of the patient he became convinced that the case was not one of hernia, but a dilatation of the saphenous vein.

DR. BREWER said that only a week ago he had a case of supposed double femoral hernia referred to him, which proved to be one of dilatation of the saphenous vein on both sides. In this case there was a distinct impulse upon coughing. The unusual softness of the tumors led one to suspect their true nature.

DR. JOHN B. WALKER said he had seen quite a number of these cases at the Hospital for Ruptured and Crippled. The diagnosis can usually be made by having the patient lie down, when the tumor disappears, the blood imparting a certain thrill to the finger as it passes out.

CARCINOMA OF THE ŒSOPHAGUS.

DR. F. KAMMERER presented a specimen obtained from a man, about fifty years old, who came to the hospital with symptoms of very severe dyspnœa, which he stated had existed for about three weeks, and was gradually increasing in severity. There was nothing to be seen about the neck. The laryngoscope showed a paresis of the right vocal cord. An inferior tracheotomy was then done, which showed that the obstruction to breathing was located below the point of exit of the trachea from behind the sternum. A rubber drainage-tube was inserted for about three inches through the tracheotomy wound; at this point it met with distinct resistance. A smaller tube, however, could be made to pass farther down.

A week later, while the patient was apparently breathing with comparative ease, he suddenly died at night. The autopsy disclosed a very small epithelioma of the œsophagus, which had given no symptoms, and a large lymphatic node which pressed upon the trachea and which had been the cause of his dyspnœa.

In connection with the above case, Dr. Kammerer exhibited a modified König's canula. The modification consists in a strong silver wire running within the lumen of the canula on the concave side; this prevents the spiral part of the canula from unwinding. The speaker said that all who have used König's canula

know that, during its repeated necessary removals, the spiral is apt to be stretched, thus rendering the instrument useless.

IRREDUCIBLE GANGRENOUS FEMORAL HERNIA.

DR. KAMMERER presented specimens obtained from a man, forty-five years old, with a femoral hernia which had become irreducible two weeks before. The operation disclosed a Littré's hernia. On one side of the loop the furrow in the intestinal wall almost reached the mesenteric border, on the other it was distant from it about half an inch. The history corresponds with the condition found. The man had passed gas and fæcal matter to some extent continuously during the two weeks of strangulation, but for the past few days he had also had fæcal vomiting. At the time of operation there were several perforations beneath the constricting ring, and general peritonitis was well established, of which he died on the second day.